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Patient perspectives of Condition Management Programmes as a route to better health, wellbeing and employability

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Abstract

Background

Condition management programmes (CMPs), delivered through primary care settings, have been identified as possible vehicles to facilitate return-to-work for individuals with chronic health problems. There is little research, however, which examines how such programmes are received by patients.

Objective

To explore patients' experiences of CMPs in terms of health, wellbeing and employability.

Methods

Four focus groups and nine semi-structured interviews were conducted in order to capture patients' perceptions and experiences regarding participation in one of five different CMPs: *Cardiac Rehabilitation; Counselling; Lower Back Pain Services; Smoking Cessation* and a *GP Exercise Referral Programme*.

Results

Experiences of the CMPs were generally positive. Respondents reported improved health behaviours (specifically better diets and increased exercise); positive psychosocial outcomes (including increased self-esteem, confidence and social support) and in some cases return to work. However, concerns were expressed about the shortness of interventions and their accessibility

Conclusion

Although condition management appears to have been well-received by participants, the findings also illustrate that there is no 'one size fits all' template for CMPs. Rather, interventions should be adapted to take account of the dynamics of specific conditions, the context in which the intervention is based and the characteristics of the individuals involved.

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Key words: psychosocial; rehabilitation; employment; welfare; fitness for work; qualitative evaluation

Introduction

Long term sickness absence is a significant problem in the UK, in terms of the certification demands placed on GPs, labour market participation rates, social exclusion, and social security costs (there were 2.7 million people claiming Incapacity Benefit (IB) at a cost of approximately £12.5 billion per annum in 2006/07).^{1,2} Stark inequalities in the number of incapacity benefit claimants exist across the UK, with the greatest proportion of claimants being found in former industrial areas, particularly in the North³ such as County Durham. Return to work and work retention for people with a chronic illness is therefore a pressing policy issue and various employability interventions and benefit reforms that aim to help tackle this issue have been initiated in the last few years. Most of these have focused on the employability side of the problem, with only Condition Management Programmes (CMPs) addressing the issue of long-term sickness absence from a health perspective.

Pilot CMPs were introduced in 2003 as part of the 'Choices' package of the ongoing *Pathways to Work* programme and were rolled out between 2005 and 2006 by Job Centre Plus to cover approximately 39% of the UK.^{4,5} Provider-led *Pathways* was subsequently rolled out nationally in 2007, with the intention that it would cover all of the UK by April 2008⁶. *Pathways to Work* is targeted at new claimants but the initiative is also available to existing claimants on a voluntary basis⁵. CMPs are joint initiatives between Jobcentre Plus and local NHS providers,⁷ targeting the three chronic conditions which contribute most to IB claims: mental ill-health; cardiovascular disease and musculoskeletal conditions.⁴ The programmes adopt a biopsychosocial approach, focusing on the psychological and social factors relating to ill-health (e.g. anxiety, low self-esteem and social isolation) as well as the medical aspects.⁸ The aims of CMPs are threefold: (i) to improve coping skills to enable individuals to manage their own health conditions; (ii) to enhance quality of life; and (iii) to improve employability.^{9,10} As Lindsay, McQuaid and Dutton (2007, p.556) note, coping skills "can be the crucial element in a process of personal development towards a return to work".¹¹ A recent review by Dame Carol Black¹² highlighted the important role GPs can play in managing sickness absence

and, although CMPs tend to be delivered by allied health professionals, there are opportunities for GPs to be involved in championing the programmes and supporting patients during the return to work process. The importance of CMPs in the UK is increasing due to the replacement of Incapacity Benefit with Employment Support Allowance (ESA). The new two-tiered system involves the ESA, payable at the same rate as Job Seekers Allowance and an Additional Support Allowance for those judged incapable of working by a medically administered test.¹³ Individuals deemed sick but fit to work must participate in some form of work related activity, such as *Pathways to Work* (which incorporates CMPs) in order to receive additional support. For a more detailed discussion of the implications arising from the introduction of ESA see Bamba 2008¹⁴.

CMPs have been evaluated nationally^{4,7,10,15} but mostly in terms of their employment effects. Those evaluations that have been conducted have mainly considered the views and experiences of CMP practitioners or IB Personal Advisers^{4,10,15} and there is little research into patients' experiences of CMP.⁷ The evidence base in relation to CMP for mental health conditions is particularly limited, which should be of concern, given the large numbers of patients with mental health conditions on IB.¹⁶ This small scale qualitative study is therefore the first to examine patients' experiences of the CMP in terms of health impacts (lifestyle/behavioural changes and pain management) and psychosocial wellbeing, as well as employability. Taking experiences from five CMPs in one locality (County Durham), it thereby provides an in-depth evaluation of this prominent, primary care based, return to work intervention. While various models of CMP provision have been adopted in different areas nationally, the CMPs evaluated in the Durham locality have been largely implemented on a 'one size fits all' basis, with policymakers assuming that the format of weekly group sessions over a specified time period (6 or 12 weeks), with little opportunity for follow-up support (see Box 1), would be appropriate for all of the CMPs. Here we use qualitative methods to explore patients' views and situated experiences of CMPs in terms of health, wellbeing and employability. Rather than concentrating on the effectiveness of CMPs as defined by return to work rates, this study provides

important insights into the meanings patients attached to CMPs; in other words what they perceived was useful and what was problematic or limiting about the programmes in terms of their impacts on health and wellbeing as well as on employability. Experiences of participants involved in the following CMPs were explored: *Cardiac Rehabilitation; Counselling; Lower Back Pain Services; Smoking Cessation* and a *GP Exercise Referral Programme*.

Box 1: Study context - County Durham

Methodology

Patients' experiences of the CMPs were explored using a combination of focus groups (n=4) and semi-structured interviews (n=9). Focus groups were identified as the method of choice in order to capture the views, opinions and experiences of a range of individuals participating in the *Cardiac Rehabilitation; Lower Back Pain Services, Smoking Cessation and GP referral for exercise programmes*.¹⁸ However, in the case of the *Counselling Service*, it was deemed more appropriate by the researchers and the project co-ordinators to conduct interviews (n=6) individually (either face-to-face or by telephone, depending on the participants' preferences), given the nature of the intervention and the sensitivity of the issues involved. Three additional case study interviews were also conducted for the *Cardiac Rehabilitation; Lower Back Pain Services and Smoking Cessation* programmes. In total 25 participants were involved in the study.

A thematic topic guide (see Box 2) was devised for the focus groups and adapted for the semi-structured interviews. This was informed by the existing literature-base relating to return-to-work schemes and by the previous experiences of the research team. Participants were recruited through the intervention leaders who adopted a 'gatekeeping' role. Although briefed to recruit participants offering a broad range of views, it must be acknowledged that these gatekeepers may have – either wittingly or unwittingly – recruited individuals who most regularly attended the CMPs and who were

therefore most engaged with the programmes. As a result, these individuals may have been more likely to offer positive responses than other participants. However, the fact that many of the research participants offered criticisms of the interventions and that several focus group participants claimed some CMP participants had been unable to attend the focus group because they had already returned to work, suggests that this was not necessarily the case.

With the exception of the smoking cessation programme (where the intervention was delivered in the workplace) all interviews and focus groups took place at the venue where the CMP had been delivered and were audio recorded, after the consent of participants had been obtained. It is possible that by using the venue where the CMPs took place to conduct the focus groups and interviews participants may have felt inhibited and unable to express their honest opinions of the CMPs. However we did explain to participants that the feedback they provided would be anonymised and we did not find any evidence to suggest this may be occurring. The possibility of self-censoring is common in focus groups, where individuals may refrain from making contributions due to the nature of the group context or the environment in which the focus group is conducted¹⁸.

Focus groups varied in length, lasting between 30 and 60 minutes, and involved between four and six participants. Two members of the research team were present at each of the focus groups, with one leading the discussion and the other taking field notes and checking that all of the topic guide themes had been addressed. One-to-one interviews for the counselling CMP ranged from 15-53 minutes and were conducted face-to-face by KJ (n=3) or by telephone by KJ and by KS (n=3). The research was approved in advance by [name removed for anonymity] University Ethics Committee.

Audio data were transcribed *verbatim* and fully anonymised before thematic analysis was undertaken by two experienced qualitative researchers working in collaboration (KJ & KS). A framework for analysis was derived abductively, partly from the study objectives and partly by exploring the data

and identifying themes and sub themes from interim analysis of transcripts.¹⁹ This process of analysis was facilitated using the qualitative analysis software package *Atlas Ti* (Version 5.0.66, Atlas Ti Scientific Software Development GmbH, Berlin) and the emergent themes were checked for consistency between authors. Researcher interpretations and emergent themes were then discussed by the research team as a whole, in order to help resolve any discrepancies. Extracts from interview and focus group discussions are presented in the following section, which aims to draw out the most salient themes from the analyses. The acronym accompanying each quotation refers to the CMP being discussed (see Box 1). Demographic information of focus group and interview participants are included in Table 1. Participants included patients on short and long term sickness absence as well as individuals who were in work and used the programmes to manage their condition to prevent movement out of the labour market.

Table 1: Demographic information of study participants

	Number of participants	Gender		Age range (years) where this information was available			
		Female	Male	25-34	35-49	50-64	65+
<i>CMP - Back Pain Service</i>	5	3	2			5	
<i>CMP - Cardiac Rehabilitation</i>	5	1	4			4	1
<i>CMP - Counselling Service*</i>	6	5	1	1	2	1	
<i>CMP - Smoking Cessation Service</i>	4	3	1	1	3		
<i>GP Referrals*</i>	5	3	2			3	1

*Data on age missing due to participants declining to provide this information

Box 2: Research Topic Guide

Findings

Thematic analyses uncovered a range of overlapping themes in the data, which are set out in Figure 1. Health impacts were defined in terms of impacts on lifestyle and behaviour and pain management capabilities; this included impacts relating to improved mobility, increased frequency of exercising and

the development of coping strategies. In terms of psychosocial impacts (relating to feelings of wellbeing), respondents described a number of outcomes, including increased confidence and self-esteem, as well as the development of a more positive attitude to rehabilitation or condition management. Some participants also described positive outcomes in relation to employability, including retaining employment, moving back into employment after a period of sickness absence, and/or increased aspirations regarding the labour market. The complex and overlapping nature of the perceived impacts of the programmes is highlighted in Figure 1, where, for example, changes with respect to employability such as return-to-work after sickness absence are contingent upon psychosocial outcomes like increased confidence or lifestyle impacts such as decreased reliance on medication. It should be noted, however, that both focus group and interview participants expressed a number of concerns about the structure and delivery of the interventions (such as a lack of follow-up and difficulties in accessing services), which have the potential to limit the positive impacts of the programmes (see Figure 1).

Figure 1: Key themes to emerge from the analysis

Health related experiences

Several respondents suggested that taking part in a CMP had brought about significant changes in their day-to-day lives in terms of diet and exercise regimes:

'I changed my diet from the day when I got told what the fault was. I was fourteen stone then before I went for the operation. I went down to twelve. That was in three months. Basically, what I had when I was there was none of the fried stuff, bacon, sausages, no pies, no cakes, no biscuits, no fish and chips, and just apples and oranges... I don't even eat salt now.' (CR)

'I'm more agile now than I was before I came. I am, I'm definitely more agile.' (GPR)

Changes in lifestyle-behavioural parameters such as improved fitness and mobility were attributed to the delivery of advice and information regarding exercise and fitness, as well as to new coping strategies for pain management, as reflected below:

'It wasn't only that you were learning, it's your lifestyle, like walking, exercise like. They said do the exercise, it helps to keep the fat down as well. You don't do exercise just to build your muscles, and keep your build fitter. But it actually improves your lifestyle.' (CR)

'I've not been removed from the situation that brought about that level of distress in me, but I recognise that I cope so much better that I am so much better at being able to challenge individuals, as the situation comes up.' (C)

As the above quotations indicate, for people with long term conditions, aspects of the interventions relating to coping mechanisms and exercising were felt to be particularly helpful. This suggests that the biopsychosocial approach adopted by the *Lower Back Pain* and *Cardiac Rehabilitation* programmes, which incorporated elements of education and relaxation as well as a comprehensive exercise regime, was well conceived.

Psychosocial experiences

It was clear from all five focus group/interview discussions that the CMPs also had a range of important psychosocial benefits for participants. Participants across all interventions reported feeling more positive about their general health and wellbeing after taking part in the interventions:

'I used to come out of here after the three and half hours, whatever it was, feeling really great. Feeling positive and feeling good.' (LBP)

'And it's mental, it is, it's all in your head and I think you've got to try. Like I said, the whole time you're going through it. It's the same with your thoughts, and I have to literally turn negativity round to positiveness now.' (SC)

Similarly, many participants reported that one of the central benefits of their involvement in the intervention had been an increase in feelings of self-confidence and self-esteem. As the extract below illustrates, some participants discussed how participation in the CMPs contributed positively to their mental health:

'I think mentally it helps...[I] can get a bit depressed and I think coming out into an environment like this tends to stimulate you more, mentally as well as physically.' (GPR)

Other participants emphasised how increases in their sense of confidence helped them in more practical ways, by, for example, helping them feel more able to remain at work, as the following quotation illustrates:

'I can manage my back pain better, [it] makes me more confident, and obviously, as a result of that, I'm not taking time off work. So in that sense it was a good investment.' (LBP)

Another salient theme highlighted in each of the focus group discussions was the opportunities that the interventions provided for social interaction with other participants (and staff). This appeared to have provided a level of stimulation, support and motivation that many of the participants felt they would not have experienced if they had received the intervention on a one-to-one basis:

'And we've all like watched ourselves. We've had a laugh, haven't we? You have to have a laugh, you have to carry on.' (CR)

'And I think the group thing that works doesn't it, because you get together and you realise that other people are having the same problems.' (LBP)

'I found here being in company, it's a lot more [...] better, nice people and I thought I could do it better. I've more incentive to do things I think.' (GPR)

Participants described how they benefited from developing social support networks built on shared experiences of similar problems:

'You think you're the only one, and then you see somebody else's problems.' (CR)

'And I found the whole process valuable, particularly going along with other people who had similar problems and sharing their problems with them. I must admit I was rather cynical at first but I'm quite positive at the end of it.' (LBP)

Through identifying with others, participants often described having been able to adopt a more positive attitude to their condition and, accordingly, their approach to managing it.

Experiences in relation to individuals' employability

There were various accounts of the positive impact that these five projects had on employment outcomes. Several participants from the *Lower Back Pain, Counselling, and Cardiac Rehabilitation*

programmes described how the CMP had helped them to retain employment or return to work after a period of sickness absence.

‘I’ve had no time off work since then [referring to participation in the intervention] so touch wood. Not that I had a lot of time. I was similar to you [referring to other focus group participant]. When it’s bad you think, ‘well, when I can’t get in the car I can’t go.’ (LBP)

‘I was off [work] for about three month - March to, I think it was June. I went back, so I’ve been back all the time since then, and I’ve felt a lot better since I went back.’ (C)

The reasons underpinning movement back to work put forward by participants in these three programmes included the development of new pain management and coping strategies, a more positive mental attitude to their condition, and the incorporation of physical exercise into daily routines as a means of increasing their fitness and mobility. Similarly, in the *GP Referral* focus group there was some positive discussion about people who had been able to return to work as a result of the initiative:

‘I know quite a lot of people that’s used this. They work and find they’ve had a bad back and they’ve come and they’ve gone back to work.’ (GPR)

‘And you have access back to work. It is a good instrument to get people back to work. It’s excellent.’ (GPR)

For some individuals who did not feel ready to return to work, there was at least a sense that their desire (and in some instances, their confidence) to return to work in the longer term had been increased through participation in a CMP. For example:

‘He [the project facilitator] gave me the confidence. I thought, right, the next few weeks I’m going to go back to work. Then something else happened at home. I thought, I wish I could see [name of counsellor] just to get it off my chest. I thought, I can’t go back to work. I should go back to work but inside me is pulling me back, I can’t. I can’t.’ (C)

The above extract highlights the depth and complexity of the issues facing some participants and underlines the need for joined-up and long-term approaches that can offer a range of support.

Participants concerns regarding the CMPs

Having highlighted the varied benefits of CMPs that participants reported, it is important to also reflect on some of the concerns that were raised. One concern, which appeared to be important for participants across all five CMPs, was the continuity (or otherwise) of interventions and the opportunities for longer-term support. In this respect, there was significant variation both between what the various projects offered participants and also between the requirements of individuals with different conditions. For example, the opportunity for follow-up support was provided in both the *Cardiac Rehabilitation* and *Lower Back Pain* programmes and this was something that seemed to be appreciated by participants and which they believed was likely to help them to cope with their condition and to continue to benefit from what they had learned during the programme:

'It would be a bit of a shame if say after twelve weeks it just stopped, and that's it, no more... At least there is a follow-up system.' (CR)

'Because if you feel you're not doing the exercises, and sometimes you do do things that you think, is that right? Whereas if you can come, you can do it again as a group and it refreshes what you're doing and how you're doing it.' (LBP)

In contrast, the *Counselling* and *GP Referral* programmes offered little in the way of a follow-up to the programme. In several instances, the use of such short term programmes was felt by participants to be unhelpful and they reported feeling that, whilst they had been actively encouraged to participate, they had been left unsupported once the intervention ended:

'After the 12 weeks the only issue I'll probably have is, like I say, if I'm working, [inaudible] start working when do I come? Because apparently you've got a cut off time. And I find that probably a little bit unfair.' (GPR)

'You can't put a timescale on it can you? Really, you're going to need support for years.' (SC)

The above quotations also serve to highlight the problematic issue of dependency, whereby individuals participating on the CMPs are unable to cope without the programme's support when the intervention ends. For the *Counselling* intervention, more so than any of the other CMPs, the lack of

continuity and follow-up appears to have been critical to participants. Indeed, it could be argued that, because counselling services encourage individuals to reflect on what are often very personal and sensitive issues, to leave clients without the possibility of a follow-up after a six week period is potentially damaging, as the following interviewee reflected:

'After quite a few weeks of not seeing him [the counsellor], that I slipped back a bit....I probably need a long time for counselling....I feel I've gone back a little bit instead of going forward, because he did give me confidence about myself, but now it's gone back.' (C)

These data suggest that the short-termism of some of the interventions raises important issues relating both the efficacy and the ethics of short term CMPs that offer no follow-up. It also appears to undermine the overarching objective of encouraging movement into employment.

The absence of follow-up arrangements was not the only issue that clients of the *Counselling* service expressed concerns about; several also reported that they found the process of having to access the service via their GP both difficult and time consuming. As the extract below indicates, some of the interviewees felt that the referral process could be made more streamlined and efficient, and less medicalised, especially in cases where individuals already recognised that they needed to access counselling:

'So why has the middle link got to be a doctor? Again, I agree with the fact that somebody might not know that they have a problem, an issue, they require counselling, but for learners and the educated people that do, there should be an alternative there, thinking, 'look I need help, I know it's very professional, I need counselling, I can get in touch with a counsellor'. [Then] there's no need to go through the GP.' (C)

Another participant described her/his frustrations in negotiating access to her/his GP:

'I mean, as I say, I couldn't get through to my doctor. I mean my doctor's lovely but I just couldn't get past the receptionist.' (C)

Difficulties in securing an appointment with a GP appeared to have further demoralised some already vulnerable individuals and, in some cases, this may have compounded existing problems. To

circumvent this problem one participant suggested making counselling services available through other non-clinical routes, such as via a drop-in centre or helpline.

Finally, for those participants on the *GP referral* scheme, there was a feeling that the lack of flexibility in the timing of activities being run as part of this scheme may also have limited participation:

'Most of them are in the mornings. Most of the ... the GP referrals are mostly mornings aren't they?...I'd like to see a big change in the access there, I think'.
(GPR)

These concerns around access tended to be voiced by participants in the Counselling and GP Referral programmes specifically and were not expressed by participants in the other CMPs. This raises the question of whether different access routes to CMPs should be considered in the design of future interventions.

Discussion

Experiences of the CMPs were generally positive. Respondents reported: improved pain management techniques; positive changes in health-related behaviours (specifically better diets and increased exercise); a wide range of beneficial psychosocial outcomes (including increased self-esteem, confidence and social support) and in some cases a return to work after a period of sickness absence. The holistic, biopsychosocial approach to the programmes was considered to be particularly helpful. This further suggests that the kinds of cross-cutting approaches supported by existing research are beneficial to participants.²⁰ However, to make the approach to employability truly holistic, some focus should perhaps be placed on the 'demand' side of links with employers, rather than concentrating solely on interventions addressing the individual (the 'supply' side).^{21,22}

Concerns regarding the length of CMPs and opportunities for follow-up were noted, as was criticism regarding access to interventions. This suggests that it is important for CMPs to be flexible, accessible and tailored to both the specific needs of the individuals involved and the social contexts

in which they are situated.^{11,23} Furthermore, it is essential for short-term and narrowly focused projects to be embedded within longer-term, holistic support strategies. In other words, given the wide variations in different conditions (and in individuals experiences of those conditions), there can be no standard template for CMPs. Related to this point, is the problem of dependency and the ethics of empowering individuals to increase their coping skills and employability in a job poor environment (which is likely to have been worsened by the current economic downturn). The idea of providing short term, largely lifestyle/behavioural type programmes targeted at specific conditions in isolation is likely to be short sighted and the broader and often more complex needs of individuals are likely to be better provided for in client-centred approaches to support, which respond to changing problems and concerns. There is also clearly a role for the employers in terms of creating a supportive environment by physical, psychological and organisational means, for example by offering ergonomic work stations, courses on stress management or flexible working conditions to facilitate return to work.

A common theme emerging from the *Cardiac Rehabilitation*, *GP Referrals*, *Lower Back Pain* and *Smoking Cessation* focus groups (i.e. the four projects which were implemented in a group setting) was the perceived benefit of support provided through group interaction. It is possible, as demonstrated in a Canadian study of return to work after prolonged sickness absence, that such social support can itself facilitate positive employment outcomes.²⁴ Indeed, the positive impacts of group interventions have been well documented in several areas relevant to general practice and primary care. For example, van Haastregt et al. (2007) showed that socialising and learning from each other were important impacts of participation in a group programme designed to reduce fear of falling in older people.²⁵ Similarly, a study evaluating group support for informal carers during the process of palliative home care showed that a sense of belonging and group cohesion were benefits of the intervention.²⁶ The findings from the study presented here corroborate these observations in the context of condition management and provide experiential evidence of the benefits of intervention

delivery in group settings, which could be used to inform the design and implementation of CMPs. This is not to suggest, however, that a group setting is appropriate for all individuals experiencing all of the conditions these CMPs aimed to address as it may well be that group settings are not appropriate for individuals accessing counselling, for example. In terms of (re)connection with the labour market, the positive outcomes described by participants in the *Counselling*, *Lower Back Pain*, *GP Referrals* and *Cardiac Rehabilitation* focus groups, are in keeping with the wider evidence base for the return to work effects of vocational rehabilitation. For example, Sjöström, Alricsson and Asplund (2008) demonstrate how a multidisciplinary rehabilitation programme for back and neck pain resulted in decreased full time sick leave for a period of up to two years after the end of the programme.²⁷

Increased confidence and self-esteem, were frequently reported as benefits in all five CMPs, in addition to the other health-related outcomes, such as improved pain management, increased fitness and mobility that were reported in the four CMPs dealing with physical health conditions. Together these findings extend the evidence base on the impacts of CMPs collated from other recent evaluations, which have tended to concentrate only on employability outcomes.^{7,10} Participants' concerns relating to difficulties in accessing CMPs were also flagged up in an evaluation of CMPs from the perspective of CMP practitioners or facilitators.⁴ Similarly, the need for long term, intensive and personalised support has been highlighted by a number of authors in relation to other types of employability initiatives.^{20,11} Indeed, our conclusion that a 'one size fit all approach' is inappropriate for the design and delivery of CMPs, aligns with the findings of McQuaid and Lindsay (2005), who make a similar observation in relation to the generic design of some employability interventions.²⁸

Study Limitations

It should be noted that, as a qualitative study, our findings are inevitably context specific and capture the views of only those individuals who agreed to participate in the research. Nevertheless, the data

provide useful insights into how individuals experience CMPs and, given the comparability of the study area with other parts of the UK (in terms of, for example, IB profiles), the lessons drawn in this research may aid the design of future CMPs. The study may also provide some guidance to help GPs support patients through similar types of employability and CMP initiatives.

All of the research participants were recruited through project co-ordinators, who adopted a gatekeeping role. There is potential that this may have resulted in a biased selection of respondents as project co-ordinators may have been more likely to recruit participants whom they felt would provide positive accounts of their experiences on the CMP they were involved in. Nevertheless, the data do include a number of criticisms and concerns relating to the various projects, which suggests that we were able to engage with individuals who had experienced difficulties with, as well as benefits of, the projects. Although the aim of the study presented here was to provide insights into how individuals view and experience CMPs, future research might augment this qualitative approach by including indicators of pain management and psychosocial health that are suitable to quantitative analysis.

Conclusion

The findings we present support the function of multi-disciplinary, biopsychosocial programmes from participants' perspectives and underline the need for long term follow-up in all types of CMPs. Some commentators might argue, however, that initiatives such as CMPs place the responsibility of securing a route back into the labour market with the individual and in some ways this approach equates to victim blaming reductionism²⁹. With this in mind, the role of GPs and other health professionals (depending on capacity issues) should be promoted in the delivery of support and advice before, during and after a CMP, in order to help maintain and build on the health improvements and/or transition back into the labour market facilitated by CMPs. Moreover, of course there is a need for those delivering this type of intervention to acknowledge the broader social

determinants of ill health and to view the condition for which the patient is being treated in a wider context, thereby addressing the varied and complex needs that many individuals face. The data also offer insights into whether additional means of accessing CMPs should be considered, particularly for conditions which are often constructed by patients as being broader than merely a biomedical concern, such as mental health conditions. In addition to the importance of offering longer term support, this study suggests there can be no 'one size fits all' approach to CMPs. Instead, given the complex and varying conditions and needs of those accessing these services, there is a requirement for context sensitivity and individualised support in the design, implementation and follow-up of CMPs, accompanied by a broader strategic framework which offers the potential for longer-term support and advice.

Ethics approval

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Conflict of interest

None

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